REQUEST FOR TERMINANTION OF PREMIUM HOSPITAL AND/OR SUPPLEMENTARY MEDICAL INSURANCE

DO NOT WRITE IN THIS SPACE

The completion of this form is needed to document your voluntary request for termination of Medicare coverage as permitted under the Code of Federal Regulations.

Sections 1838(b) and 1818(c)(4) of the Social Security Act require filing of notice advising the Administration when termination of Medicare coverage is requested. While you are not required to give your reasons for requesting termination, the information given will be used to document your understanding of the effects of your request.

NAME OF ENROLEE	**MEDICARE CLAIM NUMBER**

NAME OF PERSON, IF OTHER THAN ENROLLEE, WHO IS EXECUTING THIS REQUEST	THIS IS A REQUEST FOR TERMINATION OF:	DATE SUPPEMENTARY INSURANCE WILL END
	MEDICAL INSURANCE	**June 7, 2010**

I request termination of my enrollment under the above provisions of title XVIII of the Social Security Act, as amended, for the reason(s) stated below:

I reside in Venezuela and Medicare coverage does not apply to me while abroad. Please STOP all Medicare Part B deductions at once.

I UNDERSTAND THAT IF I AM REQUIRED TO PAY FOR MY HOSPITAL INSURANCE, THE TERMINATION OF MY SUPPLEMENTARY MEDICAL INSURANCE COVERAGE WILL ALSO END MY HOSPITAL INSURANCE COVERAGE.

~~SIGNATURE~~	~~DATE (Month, day, year)~~
	Monday, June 07, 2010
MAILING ADDRESS:	Telephone number (Include Area Code)

FORM HCFA 1763 USGPO 1984-421-101/14393